IMPROVE RURAL EMS
VISION SUBCOMMITTEE #7

Mission Statement and Goals:

To propose principles to improve rural EMS which include 1) providing a means in which medical transportation can be accessible throughout the state, 2) facilitating the sustainability of rural EMS by enhancing networking of health care resources, 3) providing access to care in EMS rural health, and 4) maintain existing funding and expand funding where inadequate.

I. <u>Provide a means in which medical transportation can be accessible throughout the state.</u>

Findings

California is a rural state. Of the 58 counties, 43 are considered rural, mostly on the basis of population density. Seven of our counties meet the federal definition of " frontier area" which means that they have a population density of six or fewer persons per square mile. One sixth of the State' s residents live in rural counties. Although rural populations tend to need more medical attention since they are older, poorer and with higher unemployment rates than their urban counterparts, we are disadvantaged due to the distribution of most of our health care resources. In developing a plan for rural health care, the Office of Statewide Health Planning and Development recently recommended that rural health leadership and advocacy efforts be coordinated at the state level.

Task Statement 1:

Define a role of EMSA regarding interfacility transfers on a statewide basis.

Recommendations:

Requests for procedures and medications beyond the basic scope of practice.

A) **Frequency of reviews**

Submissions for review by the EMS Authority may be made at any time during the year. Reviews by the SOPC will be done at quarterly intervals, as needed. Packages will be reviewed at the next scheduled meeting of the committee following receipt of a complete package. If a package is submitted less than thirty days before the next meeting, there may be inadequate time for review. For Category I requests, only one (1) copy is necessary for submission to the EMS Authority. For

Category II requests, ten (10) copies of the submission should be sent to facilitate the review process.

(B) **Legal Issues**

The paramedic scope of practice within a jurisdiction should only include those items in the EMT-P Basic Scope of Practice and those formally approved in writing by the EMS Authority. Items not approved, or those denied, by the EMS Authority should not be used. Submission of a request to the EMS Authority to use a medication or procedure should not be considered approval to begin using the drug or procedure. Use of items not approved poses a liability issue for the local EMS Agency. It is recommended that training, purchase of equipment, or other implementation strategies not be done until approval is received. This eliminates potential waste of time and money in the event the procedure of medication is denied or implementation is delayed.

(C) **Submission of Requests - Undefined Scope of Practice**

The Health and Safety code requires that any skill or procedure beyond the basic Scope of Practice be reviewed by the EMDACSOPC and approved by the EMS Authority before it is implemented. Local EMS Agencies must submit a request for approval -*Undefined Scope of Practice* (Form EMSA-0391) to the EMS Authority to add any medications and procedures beyond the basic Scope of Practice. The medications and procedures approved by the EMS Authority are based on the treatment protocols and the indications as submitted by the local EMS Agency. If a local EMS Agency utilizes a particular modality for a different role or indication than originally submitted, the EMS Authority must be notified. If a local EMS Agency discontinues the use of a procedure or medication, the EMS Authority must be advised. To facilitate a review of each medication and procedure requested, the SOPC divided all skills and procedures identified in an initial survey several years ago into three categories - **Category I**, **Category II** and **Category III.**

Category I items have demonstrated efficacy in prehospital care.

Category II is defined as items which are controversial as to their efficacy in prehospital care.

Category III items are felt by the committee to generally lack any apparent efficacy or usefulness in the prehospital setting.

Task Statement 2:

Emergency Medical Technician - Paramedic training in other parts of our country.

Recommendations:

In order to meet the needs of patients in rural settings, expand EMT-P training to all EMT-Ps along with a designation of critical care transport paramedic which meet the needs of the critical patient both pre-hospital and interfacility transports.

Allow the CCEMT-P to utilize skills/medications only during an interfacility transport.

Task Statement 3:
Implement Critical Care Emergency Medical Technician Paramedic Training.

Recommendations:
Implement and designate a CCEMT-P level of training which would allow rural communities to have faster accessibility for transportation of acutely ill or injured patients to a trauma center or for higher level of care for medical/surgical purposes. Limit this designation/scope of practice to interfacility transports to reduce the oversight/monitoring requirement of the state while continuing to meet the needs of our rural communities.
Since the State of California requires EMT-Ps to meet and test at the national standard level, implementing /allowing the national formulary and training standards would also meet the needs of our rural communities while still allowing selective protocols/procedures to be controlled at the local EMS Agency level.

Network of Health Care Resources and Delivery Systems to Facilitate Rural EMS:

Findings
A major and vital function of rural hospitals is the provision of emergency care. Rural hospitals, especially those located in remote communities, usually do not have the option of closing down their emergency-care services to contain costs. Currently, more than 55 percent of California' s 72 small and rural hospitals are losing money on patient care operations. This is due mainly to low utilization and a lack of economies of scale. Closure of one of these hospitals would mean the loss of most local health care services and likely have devastation effects on the local economy. These closures could critically affect access to care - particularly emergency care for isolated community residents and the thousands of tourist that visit these areas each year. A policy needs to be articulated by the state that affirms the importance of local emergency medical services as well as a commitment assuring that these services remain available.

Task Statement 1:
Over the past 10 years, several alternative models for rural hospitals have been proposed. The goal has been to develop a hospital design that is feasible in isolated areas with small populations and low hospital utilization so some level of acute services can be maintained.

Recommendations:
Regulations need to be developed and revised to reflect the unique problems of rural EMS delivery systems.

Task Statement 2:
Over the past 10 years, several alternative models for rural hospitals have been proposed. The goal has been to develop a hospital design that is feasible in isolated areas with small populations and low hospital utilization so some level of acute services can be maintained.

Recommendations:
Innovative alternative models, including new facility and staffing models, need to be designed and tested with decision based on data analysis (as appropriate - noting problems with small numbers) to assure local emergency care services.

Task Statement 3:
Most rural communities experience health care provider shortages. The loss of acute services may aggravate recruitment and retention of physicians, as many require that hospital services be available locally for their practice. A small number of physicians providing 24-hour emergency department coverage plus full-time clinic hours could create quality of life and time-commitment problems for these physicians. A sufficient number of nurses need to be available locally to adequately cover all scheduling and on-call needs, while providing enough work hours during low census periods for the nurses to maintain a living wage.

Recommendations:
Networking among local governments, EMS agencies, and regional providers need to be encouraged and facilitated in order to develop sustainable rural emergency services. Cross training and multiple-skills certification create flexibility within the nursing staff, which addresses the scheduling needs of nurses and helps to meet specific regulatory-service requirements for staffing.

Task Statement 4:
Ensuring quality and proficiency of patient care is a major challenge for isolated facilities with low patient volumes. Barriers to implementing an effective quality-assurance program include small medical staffs with few peers to
review records, discuss cases and proctor, limited data available to trend or compare outcomes and lack of funds and resources necessary to maintain a formal quality assurance program.

Recommendations:
Scope of practice, continuing education requirements, and credentialing need to take into consideration the realities of staffing issues in the isolated rural regions of California. An evaluation of areas where flexibility to these requirements can be granted without undo compromise to quality should take place.

Task Statement 5:
Maintaining compliance with regulatory staffing requirements in a scaled down emergency room model would require a smaller work force. Although the scope of practice for the emergency medical technician-paramedic decreases the need for an MICN ride-a-long for patient transfers, certain patient treatments and procedures require additional oversight and management.

Recommendations:
Location of the ambulance services will affect the staffing requirements. A locally-based ambulance service will require more support from the local freestanding emergency department than an ambulance originating from a base hospital. Arrangements might be made for the designated base hospital to provide additional staffing as needed.

Task Statement 6:
There is no specific statutory category of licensure for freestanding emergency departments in the California Health and Safety Code. Under the current statutory and regulatory format, a freestanding entity providing emergency department services would require licensure as either a clinic, as defined in the Health and Safety code, or must be part of a licensed general acute care hospital.

Recommendations:
The regulatory requirements for an emergency room, staffing and transport would need to be modified in most states before this model could be implemented.
Proposals to subsidize the continue access to rural EMS need to be explored at both the state and local levels.

Provide access to care in EMS Rural Health:

Findings
EMS in rural areas have not achieved the same level of advancement that it has in urban areas, due to the characteristic of rural areas including: long travel distances, hazardous terrain, poor roads, lack of medical personnel and providers, and in general populations that are older, poorer, less educated, high unemployment and hazardous occupations. Sparse populations covering large geographic areas add to the expense of providing

emergency care. This issue, coupled with the lack of mechanisms for funding, make the provision of EMS services a real challenge.

Task Statement 1:
It is essential to the health of Rural communities that the EMS system be integrated into a health care system that is cooperative, shares limited health care resources, provides a broad education to the EMS providers, recognizes innovative methods of health care delivery and is appropriately reimbursed. There have been more than 20 hospitals closed in the past ten years and alternate means of health services have been developed but communication for the alternate source is non existent. A stranger to a community must seek out care. Signs should be developed which clearly states where Urgent Care and First Aid Facilities are located.

Recommendations:
Federal legislative efforts to enhance the establishment of rural networks to include EMS and Trauma Systems as mandatory components.
Federal legislative efforts to define and support innovative hospital conversion, limited service hospitals or medical assistance facilities should recognize the importance of integrating EMS as part of the overall system of care in rural areas.
Federal and State efforts to support standby emergency rooms or freestanding ERs with funding available to assist local counties to have this type of service available.
Universal signs should be developed to notify the public where Urgent Care and First Aid Stations are located.

Task Statement 2:
Rural EMS still relies on volunteer personnel in most areas. Volunteers can be effective, but only with adequate resources, a clearly delineated context and strong nuturing.

Recommendations:
State and regional EMS infrastructure that both sets expectation and provides assistance to meet expectations is critical. Similarly, the fine line between a clear regulatory framework that protects the public and flexibility to pragmatically meet local needs is essential. Protocols approved by local medical director and local EMS could provide these safeguards.
State EMS lead agencies should be clearly authorized by law and adequately funded to ensure that EMS has sufficient legal basis, authority, resources and leadership to provide adequate training, communications, medical direction,

personnel, systems development and integration, vehicles and equipment, data collection, quality improvement and research.
Federal funds for the Preventive Health Services Block Grant, of which almost all 10% is used by the State to fund EMS efforts and the EMS for Children Program need to be held at current or higher level.
EMS lead agencies at all levels should have a legislative mandate, expertise, flexibility and resources to provide needed support and technical assistance to EMS systems in rural communities.

Task Statement 3:
The issue of cross border relationships is difficult in the nations vast rural areas where sparse populations and resources require interstate transportation by air.

Recommendations:
State-by-state regulations should be established to assist in interstate air and ambulance transfer.

Task Statement 4:
The implementation and success of EMS education in rural areas has a variety of challenges: limited student pool, a small number of qualified instructors, insufficient educational resources, limited access to supervised clinical experiences, limited exposure to various conditions and patients, problems with skill maintenance in low volume, lack of knowledgeable and active medical supervision and inadequate QA.

Recommendations:
Educational resources at the federal and state level are essential and this can be accomplished through distance learning using telecommunications techniques, provision of incentives for instructors to conduct satellite courses in remote areas, involvement of university medical centers and area health education centers to provide outreach education programs to rural areas and flexible scheduling to accommodate the lifestyle of the rural volunteers.
Training and certification reciprocity with adjacent states should be permitted by the local EMS agency to recognize normal marketing areas.

Task Statement 5:
The entire EMS system is initiated by a call for help. Only about 78% of the people in the US have access to 911 syste. Increasing this system has been technologically upgraded. Although these aspects of EMS access has improved, there still are challenges to be met in the rural areas.

Recommendations:
Federally there should be nationwide implementation of the enhanced 911 emergency numbers, coupled with rural addressing, to ensure that all citizens have better access to health care. Innovative communications approaches, including satellite, telecommunications, telemedicine and cellular technologies, must be supported nationwide, but particularly in rural areas.

Task Statement 6:
Shortages of all health professional in rural areas create an additional barrier to EMS. Local physicians may lack training, interest or incentives to participate actively as EMS director.

Recommendations:
State EMS offices should be encouraged to develop specific outreach efforts for training and supporting rural physicians to serve as EMS directors, including the use of distance learning techniques. Technical assistance and incentives should be provided to physicians in community health centers and rural practices. In some remote areas, non physician providers should assist in the supervision of EMS personnel under the direction of a physician through long distance learning sites or telecommunication.

Task Statement 7:
The opportunities for public education and prevention activities are greater in rural areas than in larger, more complex urban areas. In rural areas, EMS personnel are known in their communities. Community-based prevention activities are targeted to issues of genuine local concern based upon immediate problems, i.e., hunting injuries, water safety or farm safety.

Recommendations:
Federal and State EMS offices, in partnership with public health agencies, should continue to develop and distribute public information resources to local EMS providers to be tailored for local use. School systems should build this into their curricula and it should become a part of their health programs.

Task Statement 8:
When a hospital decides to close, there should be a central point of contact for all of the information required to make this process as simple and uncomplicated as possible with alternative sources of health care delivery suggestions. Rural hospitals have less funding for staff to attend state meetings thus information is scarce and not readily distributed to local health care officials.

Recommendations:

A central center should be developed, such as a reference library on the web site, where one can access information on who to call for free standing pharmacy license, radiology license, license and certification applications, hospital closure requirements, educational seminars, satellite training programs and classes, etc. This information could be publicized through media publications via EMS and Public Health Departments.

There should be more cooperation between State health care departments and less punishment type activities. Proactive help within the licensing and certification department with quarterly compliance checks after the implementation of a new law should be appreciated. Proactive assistance not retroactive withholding of payments which caused the closure of health care facilities in many rural areas. We should all be working together to make the legislators mandate of health care for everyone as painless as possible.

The ORHP staff of professionals offers expertise in rural health services, financing and research. Office activities are funded directly thorough Congressional appropriations. For the year of 1997 appropriations total $39.5 million. This is a service most rural areas are not aware of and therefore not taking advantage of their help. This service needs to be advertised extensively.

Maintain existing funding and expand funding where inadequate

Findings

In most rural settings, emergency medical care is provided through volunteer, community and government efforts. Call volumes are low and therefore economic incentives for private operators are minimal. The result is that district hospitals, small district fire departments and volunteers step forward to fill the service provider void. There is a strong need for assistance in providing critical services in these low volume, low tax based communities that provide life saving services to not only their residents but visitors as well.

Task Statement 1:

In 1992, EMSA conducted a study *a review of unmet rural needs and alternatives* which identified problems confronting rural EMS systems. Of the list of problems, Funding of Services was identified as the second most severe problem. Forty four percent of the EMS agencies (an 87% response) yielded this result.

Recommendations:

Nearly all options for improving rural EMS rely on improving access to funds. Even with the limited federal and state funding programs, priority must be given to rural interests. Technical assistance should be given to rural areas to improve fee-for-service capabilities, to evaluate subscription programs and for the development of special benefit tax districts.

State initiatives are needed to offset the tremendous burden of visitors to rural areas.

Task Statement 2:

Funding of rural EMS is critical to the success of all EMS providers, from individual volunteer programs, fire departments, ambulance services to licensed hospitals.

Recommendations:
Existing funding programs especially Medicare must continue to recognize the needs of the spectrum of rural EMS providers.

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